was drained. Contrary to the procedure of many operators, no attempt was made to perform immediate gastro-enterostomy, because it was thought the added shock would prove detrimental in many cases, and also because it was felt that many cases of gastric ulcer recover after perforation. It is noteworthy that the majority of the patients remained free from subsequent gastric disturbances after treatment.

The Interpretation of Functional Renal Tests with Special Reference to the Significance of Minimal Excretion of Phthalein and Indigo-carmin.—BEER (*Ann. Surg.*, 1916, lxiv, 434) says that the last word in functional renal tests is still far off. The practical value of these tests becomes more and more evident as one succeeds in improving the interpretation of the facts elicited. In research along these lines one encounters puzzling contradictions, and it will take much more work to explain many of them. Why a given kidney (*e. g.*, a case of ureter stone) secretes more urea than its mate, but fails to excrete indigo-carmin while its mate does it normally, or why a patient dies of uremia while the phthalein output is normal or almost normal, illustrate some of the perplexities that one encounters. The important practical point in Beer's work is to arrive at an understanding of the significance of zero or minimal excretions. From a study of 17 cases, he concluded that: Extrinsic causes (usually obstructive in character) may lead to permanent symmetrical renal damage, evidenced by minimal or zero excretion of phthalein or indigo-carmin associated usually with high blood urea and high incoagulable nitrogen blood content. Operation in these cases will be of no permanent benefit, and even the slightest (in one case the passing of a cystoscope) may bring on a fatal uremia. Similar extrinsic causes may lead temporary renal damage evidenced by the same phenomena. Operation in these cases, particularly after adequate preliminary treatment, will be rarely followed by uremia. These two wholly different types of cases can be differentiated by removal of the usual causative factor, *i. e.*, relief of the obstruction, either by use of indwelling catheter, of regular catheterization, or by preliminary cystostomy under local anesthesia or gas. If the case is of the first type, no marked change in the renal output will result, whereas if the case is of the second type, the renal output will regularly improve. A similar low combined output may be caused reflexly (inhibitive or toxic) by more or less extensive disease of one kidney, while the other kidney is adequate and improves in its function after removal of its diseased mate or after relief of the pathological condition in its mate. A low combined output may also be due to bilateral intrinsic causes and improvement in these cases is possible only after operative attack on the kidneys, or the kidney, if single, under an anesthetic which has no injurious effect on the diseased parenchyma and provided no severe wound infection or other septic complications, etc., which overtax this parenchyma, develop.

The Treatment of Genital Tuberculosis in the Male.—CUNNINGHAM (*Surg., Gynec. and Obst.*, 1916, xxxiii, 3825) says that the material upon which his communication is based is from the postmortem and clinical data of the Boston City Hospital; the Long Island Hospital, where there is a large tuberculosis camp; private cases; and a survey of the

literature. In 4250 autopsy records he found 35 instances of tuberculosis of the epididymis, the most common lesion of the genital tract to be observed clinically, in which a microscopical examination as well as a gross description of the condition of the prostate and vesicles is recorded. He found 86 clinical cases of tuberculous epididymitis. A consideration of the literature, both postmortem and clinical, shows that tuberculosis of the genital tract in the male, is most common in the epididymis, and from the epididymis the disease extends along the vas, either by continuity or lymphatics to the vesicles and prostate. The postmortem and clinical findings show that the great majority of cases of genital tuberculosis have active tuberculosis elsewhere in the body, the infection in the genito-urinary tuberculosis being a secondary one. It must be considered that the majority of cases of tuberculous epididymitis have tuberculosis of the vesicles and prostate on the corresponding side, whether the condition can be demonstrated by physical examination or not. Cases of genital tuberculosis often have associated tuberculosis of the bladder and kidney, and a cystoscopic examination with catheterization of the ureter should be a rotation procedure, in each case, before the possibility of such associated infection can be eliminated. In the opinion of Cunningham, the best treatment for the local condition, in most instances, is to remove the scrotal focus by epididymectomy or castration, and this should be followed by injecting the vas with a dram of crude carbolic acid, with the hope of eradicating the disease from the genital tract. The destruction of the local focus is but the first step in the process of immunizing the patient against fresh outbreaks of the disease; and the hygiene and tuberculin should be made use of indefinitely, as they serve further to aid in a rational way, the immunizing power of the body against remaining lesions.

Perforation in Typhoid Fever. — EDDY (*Surg., Gynec. and Obst.*, 1916, xxxiii, 451), from a report of one case and an extensive study of the literature, concludes that: While perforation varies greatly in different epidemics, about 12 per cent. of the total death-rate is due to this complication. Perforation occurs in about 3 per cent. of all cases treated. It is relatively infrequent in children. Statistics show that 80 per cent. of total perforations occur in the lower ileum. The majority of cases perforate during the second and third week. Diarrhea is an important factor in its production. Acute abdominal pain in the course of typhoid should always be taken seriously. The sudden rise of blood-pressure is positive evidence of perforation, while an unchanged pressure is not of negative value. The importance of a careful study of the blood cannot be overestimated. The welfare of the patient depends upon our ability to differentiate between the symptoms of perforation and those of the resulting peritonitis. The treatment of perforation is surgical, and the death-rate is in inverse ratio to the length of time allowed to elapse before operation. Opiates are indicated as soon as perforation has taken place and should be continued until the peritonitis has become well localized.

The Treatment of Fractures by Nail Extension.—DYAS (*Surg., Gynec. and Obst.*, 1916, xxxiii, 478), on the basis of five cases treated by this method and a study of the literature, says that Steimann's nail exten-